



FH
[REDACTED]

STATE OF WISCONSIN
Division of Hearings and Appeals

In the Matter of

[REDACTED]
[REDACTED]
[REDACTED]

DECISION

CWA/150571

PRELIMINARY RECITALS

Pursuant to a petition filed July 09, 2013, under Wis. Admin. Code §HA 3.03, to review a decision by the Include, Respect, I Self-Direct program (IRIS) in regard to Medical Assistance (MA), a telephonic hearing was held on August 06, 2013, at Milwaukee, Wisconsin.

The issue for determination is whether petitioner meets the level of care requirement for continued IRIS eligibility.

There appeared at that time and place the following persons:

PARTIES IN INTEREST:

Petitioner:

[REDACTED]
[REDACTED]
[REDACTED]

Respondent:

Department of Health Services
1 West Wilson Street
Madison, Wisconsin 53703

By: Jill Speer
IRIS Consultant Agency
1 S. Pinckney St., Suite 320
Madison, WI 53703-2887

ADMINISTRATIVE LAW JUDGE:

Kelly Cochrane
Division of Hearings and Appeals

FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Milwaukee County.
2. Petitioner has been receiving services within the IRIS program. The program did a reassessment on July 3, 2013. Following the assessment the program notified petitioner on July 5, 2013 that his IRIS eligibility would end because he no longer met the level of care requirement.

3. The assessor found that petitioner demonstrated independent functioning in activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Those findings led to the determination that petitioner did not meet the level of care requirement.
4. Petitioner has a history of a right eye retina detachment and traumatic optic neuropathy.
5. Petitioner filed this appeal and services continued pending this decision.

DISCUSSION

The IRIS program was developed pursuant to a Medical Assistance waiver obtained by the State of Wisconsin, pursuant to section 6087 of the Deficit Reduction Act of 2005 (DRA), and section 1915(j) of the Social Security Act. It is a self-directed personal care program.

The federal government has promulgated 42 C.F.R. §441.450 - .484 to provide general guidance for this program. Those regulations require that the Department's agent must assess the participant's needs and preferences (including health status) as a condition of IRIS participation. *Id.*, §441.466. The Department's agent must also develop a service plan based on the assessed needs. Further, "all of the State's applicable policies and procedures associated with service plan development must be carried out ..." *Id.* §441.468.

An IRIS participant must be elderly, or an adult with physical or developmental disabilities. See IRIS General Information at www.dhs.wisconsin.gov/bdds/IRIS/general.htm. The physical disabilities must be such that the person requires a level of care equal to the level of a nursing home. DHS Medicaid Eligibility Handbook, §37.1.3, available online at <http://www.emhandbooks.wisconsin.gov/meh-ebd/meh.htm>. To qualify for a nursing home level of care a person must have a long-term care condition expected to last at least one year. See Overview of the Long Term Care Functional Screen, §1.2, found at www.dhs.wisconsin.gov/lcicare/FunctionalScreen/WebCT/instructions1.htm.

IRIS plans of care are updated when a participant requests a change in the plan. See IRIS Program Policies found at www.dhs.wisconsin.gov/bdds/IRIS/IRISPolicySummary.pdf. The plans also are updated at least on a yearly basis.

The Department has developed a computerized functional assessment screening system. The system relies upon a face-to-face interview with a quality assurance screener who has at least a bachelor of science degree in a health or human services related field, with at least one year of experience working with the target populations (or, if not, an individual otherwise specifically approved by the Department based upon like combination of education and experience). The screener asks the applicant, or a recipient at a periodic review, questions about his or her medical conditions, needs, cares, skills, activities of daily living, and utilization of professional medical providers to meet these needs. The assessor then submits the Functional Screen Report for the person to the Department's Division of Disability and Elder Services. The Department enters the Long Term Functional Screen data into a computer program to see if the person meets any of the required levels of care.

If the assessor enters information into the functional screen correctly, then it is assumed that the computer will accurately determine the level of care. In this case, I find that the screen was completed correctly.

Petitioner has episodes where his "eyes black out". He reported to the Screener that this may occur two to three times per day. Except for when these blackouts occur, he is able to do his ADLs independently. Petitioner is able to do most IADLs independently, although he needs assistance with grocery shopping, paying bills and laundry. Those areas were noted in the functional screen.

Petitioner's primary explanation of his continued need for IRIS services is his inability to see during the blackouts. The IRIS program determined that those blackouts could be reasonably accommodated by petitioner waiting for the blackouts to subside in order to complete ADLs or IADLs. Part of the problem with petitioner's case is his credibility. He accused the Screener of lying, that she wrote down the things she wanted to, and cursed about it under his breath during the hearing. However, his own testimony, and that of his supportive home care (SHC) worker present at hearing, was inconsistent. They both claim that he has glaucoma; however, there is no diagnosis for this present in his medical records. He also claimed to have high blood pressure and acid reflux for which he took medication, but neither of those diagnoses or prescriptions were present in his medical history. He also takes eye drops, but again, without any evidence of a prescription for same. There is similarly no evidence to support a need for assistance with his medication administration that the SHC worker testified she did for him. The number of blackouts occurring and the duration for same varied through their testimony, but were categorized as far more frequent and severe than captured in the LTCFS. They also varied in their reports about petitioner's frequency of falls, something that also was not reported during the LTCFS. Further, if petitioner's blackouts were as debilitating as he described at hearing, one would expect that he would need help in all ADLs; however, he agreed he could shower and toilet by himself. One would also expect that he would seek the medical care he needs to identify the cause of the blackouts and any treatment for same. I also have no reason to believe that the Screener would fail to capture his falls on the LTCFS, and instead directly state that the petitioner reported no falls associated with the blackouts and reported no negative health outcomes. I find the petitioner's testimony in general to be self-serving, evasive, highly convenient, uncorroborated by significant or reliable other evidence, and generally not credible.

For the reasons described above, I conclude that petitioner does not meet the IRIS level of care requirements. I do not mean to diminish the challenges the petitioner faces, however, under the rules he does not meet the nursing home level of care. He is not substantially, functionally limited to the extent required here. I conclude that the agency's decision was correct. As noted on the LTCFS, the agency determined that petitioner *is* eligible for the Family Care Program at a non-nursing home level of care.

CONCLUSIONS OF LAW

Petitioner does not meet the IRIS level of care requirements because he is primarily independent despite his physical impairments.

THEREFORE, it is

ORDERED

That the petition for review herein be and the same is hereby dismissed.

REQUEST FOR A REHEARING

This is a final administrative decision. If you think this decision is based on a serious mistake in the facts or the law, you may request a rehearing. You may also ask for a rehearing if you have found new evidence which would change the decision. Your request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and tell why you did not have it at your first hearing. If you do not explain these things, your request will have to be denied.

To ask for a rehearing, send a written request to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy of your request to the other people named in this decision as "PARTIES IN INTEREST." Your request for a rehearing must be received no later than 20 days after the date of the decision. Late requests cannot be granted.

The process for asking for a rehearing is in Wis. Stat. § 227.49. A copy of the statutes can be found at your local library or courthouse.

APPEAL TO COURT

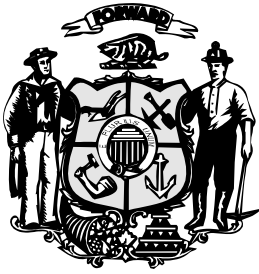
You may also appeal this decision to Circuit Court in the county where you live. Appeals must be served and filed with the appropriate court no more than 30 days after the date of this hearing decision (or 30 days after a denial of rehearing, if you ask for one).

For purposes of appeal to circuit court, the Respondent in this matter is the Department of Health Services. After filing the appeal with the appropriate court, it must be served on the Secretary of that Department, either personally or by certified mail. The address of the Department is: 1 West Wilson Street, Madison, Wisconsin 53703. A copy should also be sent to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400.

The appeal must also be served on the other "PARTIES IN INTEREST" named in this decision. The process for appeals to the Circuit Court is in Wis. Stat. §§ 227.52 and 227.53.

Given under my hand at the City of Milwaukee,
Wisconsin, this 27th day of August, 2013

\sKelly Cochrane
Administrative Law Judge
Division of Hearings and Appeals



State of Wisconsin\DIVISION OF HEARINGS AND APPEALS

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The preceding decision was sent to the following parties on August 27, 2013.

Bureau of Long-Term Support